

DOCUMENT RESUME

ED 260 355

CG 018 448

AUTHOR Rawlins, Timothy D.
TITLE Attrition in Respiratory Care: Stress versus Intrinsic/Extrinsic Rewards.
PUB DATE Apr 85
NOTE 29p.; Paper presented at the Annual Convention of the Southwestern Psychological Association (31st, Austin, TX, April 18-20, 1985). Best copy available.
PUB TYPE Reports - Research/Technical (143) -- Speeches/Conference Papers (150)
EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Career Change; *Employee Attitudes; Financial Problems; *Job Satisfaction; Labor Turnover; *Predictor Variables; *Respiratory Therapy; Role Conflict; *Stress Variables; Work Attitudes; Work Environment

ABSTRACT

A recent study (Mathews, Lira, and Neis, 1984) indicated that the reason that respiratory therapists leave or intend to leave their profession is the desire for jobs which offer more job satisfaction, better salary, opportunity for advancement, more status or recognition, better work schedules, and better benefits. Although the lack of these factors has been shown to contribute to job dissatisfaction, they cannot be solely responsible for the decision to leave the profession. The negative effects of job stressors must also play a part. A study was conducted to determine the contribution of potential stressors, measured by the Stress Index, and intrinsic/extrinsic job rewards, measured by the Job Dimension Survey, to job satisfaction and attrition of respiratory therapists (N=71) working in the critical care setting of three large metropolitan teaching/referral hospitals. While the results of the Mathew's study were replicated, it was found that therapists actually leave the work force for quite different reasons. Discriminant analysis revealed that the predictor variables contributing to the decision to leave the work force were dissatisfaction with supervision and people on the job, role stress, goal stress, and financial stress. Managers and educators in respiratory care should be aware of the stress and job reward factors responsible for job dissatisfaction and attrition, and work toward preventing their negative impact. (Author/NRB)

* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *

ED260355

Attrition in Respiratory Care:

Stress versus Intrinsic/Extrinsic Rewards

BEST COPY AVAILABLE

Timothy D. Rawlins, BHS, RRT
Air Transport Therapist
Wesley Medical Center
Wichita, Kansas

This study was completed at Wichita State University under the auspices of the Psychology Department and the Center for Human Appraisal.

Correspondence address: Timothy D. Rawlins, BHS, RRT
945 Perry Wichita, Kansas 67203
Phone: (316) 264-3894

The author is an Air Transport Therapist at Wesley Medical Center currently pursuing graduate study in Community Psychology at Wichita State University.

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION
CENTER (ERIC)

☒ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

"PERMISSION TO REPRODUCE THIS
MATERIAL HAS BEEN GRANTED BY

Timothy D. Rawlins

TO THE EDUCATIONAL RESOURCES
INFORMATION CENTER (ERIC)."

CE 018448

Attrition in Respiratory Care:

Stress versus Intrinsic/Extrinsic Rewards

(abstract)

This study was designed to determine the contribution of potential stressors, measured by the Stress Index (SI), and intrinsic/extrinsic job rewards, measured by the Job Dimension Survey (JDS), to job satisfaction and attrition of respiratory therapists (RT's) working in the critical care setting of three large (650+ bed) metropolitan teaching/referral hospitals. It is, in part, a replication of an earlier study¹ which found that therapists leave, or intend to leave, the work force due to the desire for: more job satisfaction; better salary; better opportunities for advancement; more status or recognition; more control over work environment; better work schedule; and better benefits; in order of frequency. While those results were replicated in this study, therapists actually leave the work force for quite different reasons. It was determined by discriminant analysis that the predictor variables contributing to the decision to leave the work force are dissatisfaction with supervision and people on the job, role stress, goal stress, and financial stress. Managers and educators in respiratory care should be aware of the stress and job reward factors responsible for job dissatisfaction and attrition, and work toward preventing their negative impact.

Introduction

Research into the sources of employees' job satisfaction has been linked historically to productivity, and only the recent recognition of the debilitating effects of stress on workers has forced managers to consider job satisfaction for other benefits.^{2,3} Unfortunately, it took problems like high employee turnover, absenteeism, alcoholism, and stress-related diseases to turn the emphasis in job satisfaction studies from the demand for greater productivity to a concern for the welfare of the employees themselves.

A review of the literature pertaining to stress-related "staff burnout" is beyond the scope of this paper, but recent studies of nurses⁴ and health care professionals⁵ suggest that excessive job stress leads to loss of concern for the recipients of health care services, physical exhaustion/illness, emotional exhaustion, and eventual loss of trained individuals from the work force.

Much of the job stress of health care in large metropolitan hospitals is related to the social complexity e.g.; "dual hierarchical structure-medical and administrative, large heterogeneous mix of interdependent employees, and varying degrees of professionalism"⁶ inherent to traditional hospital organization. Accordingly, managers of large hospitals often assume, as have some investigators of job satisfaction,⁷ that the forces which determine a worker's sat-

isfaction are primarily within the organizational context and, therefore, under the control of management. There is, however, some research which indicates that these organizational forces are only part of the issue, that the employee's values and beliefs determine his/her level of satisfaction.

Job satisfaction is generally considered to be the feelings one has regarding one's job. According to Smith, Kendall, and Hulin, job satisfaction refers "to persistent feelings toward discriminable aspects of the job situation. These feelings are thought to be associated with perceived differences between what is experienced in relation to the alternatives available in a given situation."⁸ Job satisfaction, then, refers to not only the feelings of an employee about various aspects of the job but also what is expected and what is actually experienced in return for services rendered. Any job aspect i.e.; opportunities for promotion, has the potential to be a satisfier, dissatisfier, or irrelevant, depending on the worker's frame of reference.

Similarly, the worker's frame of reference determines the response to potential stressors in the work environment and, according to Holt, "some aspects of many kinds of work have bad effects on most people under certain circumstances...the prevalent research paradigm is stress (independent variable) leads to undesirable consequences (depend-

ent variable) under certain parametric conditions (moderator variables)."⁹

To date, relatively few studies of the effects of stressors in the hospital environment on job satisfaction have been performed, despite the documented significance of studying hospital employees.¹⁰ The stresses studied with the greatest frequency are role conflict and role ambiguity^{11,12} and their moderators: self esteem and organizational level,¹³ organizational commitment,¹⁴ co-worker and leader support,¹⁵ participation in decision making,¹⁶ and tolerance for role conflict.^{5,16} Other research on job satisfaction in hospital employees has focused on internal/external locus of control¹⁷ and the moderating variable of group fragmentation.¹⁸

These stresses are of interest to managers because they are, to some extent, moderated by the organizational structure, and are, therefore, under the control of management. Even though tolerance for role conflict and high internal control are important in reducing stress and thereby job dissatisfaction, the hospital workplace provides a tremendous variety of stressors. Since no one has, as yet, systematically studied the various stressors under which respiratory therapists (RT's) perform in the critical care environment, managers and others desiring to lessen the impact of stress on therapists' job satisfaction are left completely in the dark as to which stresses to moderate.

And it is not at all clear that the stress experienced by therapists in the critical care environment leads to job dissatisfaction and a greater propensity to leave the work force.

This study began by posing the questions: what stressors exist for RI's in the critical care environment; does tolerance for certain stressors within the work environment enable them to perform without a decrease in job satisfaction; why do therapists leave the work force; is it due to stress-related burnout, dissatisfaction with different aspects of the job, or noncongruent expectations for the job? As Bunch suggests, "the stressors involved in the day to day practice of health care and the interpersonal relationships between staffers, managers, and other members of the health care team...are the real culprits in causing burnout in RI's."¹⁸ And burnout is, as we know, significantly related to worker's termination.²⁰

One recent study,¹ however, indicates that therapists leave or intend to leave the profession due to the desire for more job satisfaction, better salary, opportunity for advancement, more status or recognition, better work schedule, better benefits, or full-time mother (in order of frequency). Some of these factors have been shown to contribute to job dissatisfaction,^{7,8,19,20} but cannot be solely responsible for the decision to leave the profession. The negative effects of job stressors must also play a part.

For example, it has been shown that RT's experience a great deal of role stress in terms of multiple expectations^{6,22} and competing demands,⁶ and those therapists tolerant of role stress are more satisfied with their jobs than those with low tolerances.⁶ And role stress in the forms of role conflict and role ambiguity (with which this study deals) has been linked to job dissatisfaction, job related tension and anxiety, and a greater propensity to leave the organization.^{23,24,25,26,27}

This study will attempt to demonstrate that the propensity to leave the respiratory care (RC) field is multi-dimensional i.e.; a combination of stress and intrinsic/extrinsic job rewards are involved with the decision to leave, and will seek to identify the factors which contribute most to job dissatisfaction and attrition. Specifically, the author hypothesizes that: 1) positive correlations exist between stress and dissatisfaction with the critical care setting and cluster around job-related interpersonal conflicts inherent to the organization of the work unit; 2) therapists who intend to leave the work force will rank intrinsic/extrinsic rewards in the same order of importance as those therapists studied by Mathews, Lira, and Neis,¹ i.e., the therapists in this study represent an equivalent population; 3) it is possible to discriminate between those therapists leaving or staying in the field in terms of their response to potential stressors and dissatisfaction with

intrinsic/extrinsic job rewards; and 4) those therapists making the decision to leave do so due to both an intolerance for certain stressors and dissatisfaction with job rewards in the critical care setting.

Materials and Methods

Subjects. Questionnaires were distributed to a population of 110 entry level RT's in three large (650+ bed) teaching/referral hospitals in the Wichita area. Participation was strictly voluntary with the restrictions that the therapists be non-supervisory and work exclusively in the critical care setting.

Apparatus. Each participant completed a Stress Index (SI), a self-scoring, 105-item instrument developed by V. Ann and A.B. Sweeney of the Center for Human Appraisal at Wichita State University (Copyright reserved: V. Ann Sweeney, Ph.D. and Arthur B. Sweeney, Ph.D., Published by Test Systems International Ltd., P.O. Box 18347, Wichita, Kansas 67218). The SI tests the response to 15 potential sources of stress assessed by a 5-point Likert format ranging from strongly agree to strongly disagree based on questions like "I'm so busy playing roles I get confused" (calculated Cronbach's alpha for this study = 0.81405). The Job Dimension Survey (JDS), a 82-item instrument developed by T.G. Swenson, J.A. Belt, and A.B. Sweeney,²⁸ was used to determine satisfaction

with the intrinsic and extrinsic rewards of the job assessed on a Likert-type scale. For example, for "pay you get now," the subject would circle the number along the scale

Good 1--2--3--4--5--6--7 Bad

which represents his/her satisfaction with pay. One satisfaction criteria, Work Itself, represents intrinsic job rewards and eight satisfaction criteria represent the extrinsic job rewards: Hours of Work, Size of Work Unit(number of people), Regional Aspects (geographical location), Work Unit(physical conditions), People on the job, Supervision, Pay, and Opportunities for Promotion (calculated Cronbach's alpha for this study = 0.78107). The index of dissatisfaction was constructed by summing the dissatisfying indices e.g.; routine, bad, boring, etc., and subtracting the satisfying indices e.g.; fascinating, respected, useful, etc.

In addition, a demographic questionnaire similar to that used by Mathews, et al.,¹ in their study of attrition in RC was used to determine the intentions of the therapists toward staying in or leaving the field. Those leaving were asked to rank more status or recognition, full-time mother, lack of opportunities for advancement, better work schedule, better salary, more job satisfaction, better benefits, and more control over the work environment in terms of their importance in the decision to leave the field.

Procedure. 110 surveys with cover letters explaining the nature of the research and instructions were distributed by hand to the RC departments under study. The subjects were given two weeks to complete the surveys, and 71 completed surveys were collected, a response rate of 64.5%. Statistical treatment of the data was performed on Wichita State University's mainframe IBM 3081 computer using various SPSS²⁹ options.

Results

The entire battery of tests was subjected to statistical analysis, and all results have been summarized, where appropriate, to aid in the reader's interpretation. The method of analysis was chosen prospectively, with the objectives of demonstrating the relationship between perceived stress and job dissatisfaction, and to determine which SI and JDS criteria are predictive of group membership; that is, which criteria contribute to the decision to stay in or leave RC. A correlation matrix was created to determine the extent of the linear relationship between stress and job satisfaction in RC, and is summarized in Table 1. Many significant correlations at the .01 and .001 alpha levels ($d.f.=70$) exist between stress and job satisfaction, especially with regard to stressors in the work unit. For convenience, only those correlations above the .25 level are

reported. Of the 71 therapists surveyed, 33(46.5%) intended to stay in the field, 5(7.0%) were undecided, and 33(46.5%) intended to leave the field. Table 2 shows the mean ranks for the demographic survey items supposedly responsible for the decision to leave. The items are ranked in the order of their importance in the decision to leave the field, and mirror exactly the order of frequency previously cited.¹

Mean SI scores for those staying in and leaving respiratory care are shown in Figure 1. Therapists intending to stay differed from those leaving with regard to mean stress scores for attention seeking, goal stress, performance stress, financial stress, impatience, regret, and role stress. Mean JDS satisfaction scores for those therapists staying and leaving are shown, with their deviations from the mean for each JDS criterion, in Figure 2. Therapists intending to leave were more dissatisfied with each JDS criterion than those intending to stay. Therapists in general were moderately satisfied with RC (grand mean = 3.30), with the exceptions of the criteria of pay and opportunities for promotion.

The results of direct discriminant analysis performed on the SI and JDS scores for the function of staying in/leaving RC are shown in Table 3. For convenience, only those SI and JDS criteria loading above the .25 level are reported. Even though all of the 24 criteria contribute to the linear transformation describing the discriminant func-

tion of staying in/leaving RC, those below the .25 level are trivial. Although therapists cite the desire for more job satisfaction, better salary, etc., as responsible for the decision to leave the field, predictor variables contributing to the decision were actually dissatisfaction with supervision, role stress, goal stress, people on the job, and financial stress, in the order of their relative contribution to the decision. Predictor variables contributing to the decision to stay in the field were performance comfort, self appreciation, proactivity, and regional aspects, in the order of their relative contribution to the decision.

Discussion

One of the greatest threats to the internal validity of any study is the selection of participants, and many probability and nonprobability techniques have been developed to ensure that the participants selected are truly representative of the parent population. First and foremost of these techniques is random sampling, in fact, probability tables allowing statistical inferences are worthless without it. But randomness in selection is never quite attained in field settings; the researcher must recognize that bias is an unavoidable part of studying behavior in naturalistic settings, especially in view of the fact that random selection is often impossible.³⁰ In this study, for example, random sampling would have required that the sampling frame be enlarged from therapists in the Wichita area to the entire state of Kansas in order to obtain a large enough sample for discriminant analysis. Discriminant analysis requires at least two to three times the number of subjects as variables;³¹ in this case, 71 subjects with 24 SI and JDS variables barely satisfies this requirement. Convenience often determines the chosen research methodology, and statistical inference suffers as a result.

The subjects in this study were, however given an equal chance in participation, although 35% refused to return the questionnaires for unknown reasons. This response rate is

typical of mail surveys, and represents another potential source of bias if the respondents' actual feelings toward RC were extreme in one direction or the other. For each 10% decrease in response rate, one can expect an equal increase in the range by which the sample distribution could be affected by refusals, skewing the distribution of sample scores in either a positive or negative direction depending on, for example whether the therapist is highly satisfied or highly dissatisfied with RC. Rather fortunately, the distributions between those intending to stay or leave RC in this study are (entirely by chance) equal, and, in any event, extreme distributions rarely occur.³²

The therapists involved in this study represent 53% of the trained therapists in the Wichita region and 20% of the trained therapists in the state of Kansas (based on Zinno, J. & Miller, S. Respiratory Therapy Manpower Survey of the State of Kansas, unpublished manuscript). They, and those therapists studied by Lira, et al.' study¹ are roughly equivalent demographically, and appear to share the same attitudes toward RC. The results could be regarded, with some reservations, as valid for the population of Kansas therapists at large.

The many positive linear relationships between stressors in the critical care setting and job dissatisfaction suggest that job dissatisfaction increases as the magnitude of stressors in the work environment increases. dissatis-

faction in RC. Those RT's least satisfied, by virtue of their decision to leave, have a low tolerance for: goal stress (resulting from unrealistic professional goals); role stress (resulting from ambiguous or conflicting role expectations); and financial stress; and are dissatisfied with supervision (medical staff, other health professionals who direct their activities, or RC supervisors), and people on the job (coworkers). Those therapists staying do so due to performance comfort (confidence in performing familiar tasks), self appreciation (appreciating one's own worth and abilities), proactivity (deriving a sense of control from finding one's own decision opportunities), and satisfaction with regional aspects (geographical location). The implications are that persons with high self regard, comfort with their job performance, and who are "self-actualized" tend to fare better in the critical care setting than those who are intolerant of ambiguous and conflicting roles, lack the opportunity for goal-directed behavior, and resent those persons on the job who constrain and/or control their activities. Clearly, interpersonal conflicts in the critical care setting make the greatest contribution to attrition in RC.

These results present a much different picture of the factors responsible for attrition than that painted by Mathews, et al.¹ The therapists in this study, when presented a choice of items responsible for the decision to

leave the work force ranked more job satisfaction, better salary, lack of opportunities for advancement, etc., in the same order as University of Kansas graduates, but these items did not correlate significantly with either SI or JDS criteria whose reliabilities are well-established. While these factors may contribute to attrition, they represent only intrinsic/extrinsic rewards and cannot take into account the contribution of stress to job dissatisfaction, and are therefore poor predictors of attrition in RC.

The confusion over which factors are actually responsible for attrition is compounded by the possibility that someone leaving the work force for a higher-paying job may explain his/her leaving as due to "better salary" rather than to the stressful environment which contributed to his/her decision to leave. That is, therapists may leave for better opportunities elsewhere, but a combination of influences in the hospital environment caused their initial dissatisfaction. Therapists may also cite socially acceptable reasons for desiring to leaving e.g.; higher salary, better opportunities for promotion, rather than less acceptable ones e.g.; people on the job, stress of the work environment, or inability to reach professional goals.

The best predictors of attrition, at least in the population of RT's studied, are dissatisfaction with supervision and role stress. When asked if their RC training adequately prepared them for what to expect on the job, 17(24%)

answered that it did not. Their most frequent response was that they were unprepared for the lack of respect from the medical staff, which suggests that this may be the main source of conflict with supervision and a source of role stress.

The criteria of dissatisfaction with supervision, role stress and goal stress also appear to be inter-related with respect to the worker's expectations, and when he/she cannot engage in behaviors which allow expected roles and goals to be realized, dissatisfaction may result. Therapists who expect to be treated as vital members of the critical care team may experience a great deal of conflict when forced to perform a role in direct opposition to that associated with the self concept, that is; when allowed a very limited and proscribed function in patient care. Therapists who must constantly fight for recognition as a valuable member of the health care team and/or who are unable to meet unrealistic, noncongruent professional goals eventually seek job opportunities elsewhere.

Those interested in reducing the attrition of capable, well-trained therapists from the work force must work toward eliminating the stressors encountered by those therapists intolerant of stress. While some stressors seem to be inherent to traditional hospital organization, it may be possible to reduce their impact on therapists entering the work force. Efforts at reducing the impact of these stres-

sors should begin before therapists join the work force; it cannot be overemphasized that the prevention of stress must be the primary concern of those who wish to reduce attrition. While managers certainly should do what they can to reduce the potential for role stress by making the therapists' expected roles in the organization more explicit, they may have little influence on attrition after role stress has occurred. Despite the best intentions of those concerned managers who initiate support groups, their efforts have little real impact in lessening the negative effects of stress produced by conflict and ambiguity.¹⁵ Similarly, educators must eliminate goal stress produced by unrealistic, noncongruent professional goals by making clear to students that the limits of RC for professional growth are not unbounded. Unfortunately, not everyone can reach his/her professional goals, even if they are realistic.

Those expectations, however, which could allow for more satisfaction with the role of the RT i.e.: more control of patient care; autonomy; and value of the job in terms of faster patient recovery; should be promoted, in the hopes that therapists can demonstrate the value of RC to those members of the medical community who currently define, in large part, the scope of RC's activities. Respiratory care can be a fascinating, satisfying work experience which gives a great sense of accomplishment, as evidenced by the mean satisfaction of therapists with the work itself. Ironi-

cally, those therapists who decide to leave RC tend to be satisfied with the intrinsic rewards of the job, but are unable to tolerate the interpersonal conflicts occurring in the critical care environment which arise over the issue of control of patient care. Therapists must be allowed more control over patient care and the work environment if we hope to stem the tide of attrition.

ACKNOWLEDGEMENTS

Sincere thanks to V. Ann and A.B. Sweeney of the Center for Human Appraisal, Wichita State University, for their kind and patient help in this project. Their gift of computer time and advice made this study possible. Also, thanks to the therapists of the Wesley, St. Francis, and St. Joseph Medical Centers in Wichita, Kansas for participating in this study.

REFERENCES

1. Mathews P, Lira JM, Neis BR. Attrition in respiratory care. *AARTimes* 1984;8(13):32-38.
2. Selye H. The stress of life. New York: McGraw-Hill Book Co, 1978.
3. Sibling MB. The coping manager: stress, strain, and survival. *Pace* 1975;2(5):10-11.
4. Marshall J. Stress amongst nurses. In: Cooper CL, Marshall C, eds. White collar and professional stress. New York: John Wiley & Sons, Inc, 1980.
5. Maslach C. The burn-out syndrome and patient care. In: Garfield C, ed. Stress and survival. St. Louis: CV Mosby Co, 1979.
6. Posner BZ, Randolph WA. Moderators of role stress among hospital personnel. *J Psyc* 1980;105:215.
7. Schwab D, Cummings L. Theories of performance and satisfaction: a review. *Ind Relat* 1970;9:408-430.
8. Smith PC, Kendall LM, Hulin CL. The measurement of satisfaction in work and retirement: a strategy for the study of attitudes. Chicago: Rand-McNally & Co, 1969:37.
9. Holt RR. Occupational stress. In: Goldberger L, Breznitz L, eds. Handbook of stress: theoretical and clinical aspects. New York: The Free Press, 1982.
10. Georgopoulos BS. Hospital organization research: review resource book. Philadelphia: WB Saunders Co, 1975.

11. Caston RJ, Briato R. On the use of facet importance as a weighting component of job satisfaction. *Educ Psyc M* 1983;43:339-350.
12. Bateman TS, Strasser S. A cross-lagged regression test of the relationships between job tensions and employee satisfaction. *J Appl Psyc* 1983;68(3):439-445.
13. Mossholder KW, Bedeian AG, Armenakis AA. Role perceptions, satisfaction, and performance: moderating effects of self esteem and organizational level. *Organ Beh H* 1981;28:224-234.
14. Welsch HP, LaVan H. Inter-relationships between organizational commitment and job satisfaction, professional behavior, and organizational climate. *Hum Rel* 1981;34(12):1079-1089.
15. LaRocco JM, Jones AP. Coworker and leader support as moderators of stress-strain relationships in the work situation. *J Appl Psyc* 1978; 63(5):629-634.
16. Jackson SE. Participation in decision making as a strategy for reducing job-related strain. *J Appl Psyc* 1983;68(1):3-19.
17. Kasperson CJ. Locus of control and job dissatisfaction. *Psychol Rep* 1982;50:823-826.
18. Peterson ME. Co-worker and hospital staff work attitudes: individual difference moderators. *Nurs Res* 1983;32(2):115-121.
19. Bunch D. Having trouble coping? *AARTimes* 1983;7(2):31.

20. Perlman B, Hartman EA. Burnout: summary and future research. *Hum Rel* 1982;35(4):283-305.
21. Locke EA. The nature and causes of job satisfaction. In: Dunnette MD, ed. *Handbook of industrial and organizational psychology*. Chicago: Rand-McNally & Co, 1976.
22. Prewitt MW. Role expectations of the respiratory therapy practitioner as reported by the role incumbent and other health care professionals. *Resp Care* 1984;29(9):900-904.
23. House RJ, Rizzo JR. Role conflict and ambiguity as critical variables in a model of organizational behavior. *Organ Beh H* 1972;7:467-505.
24. Johnson JW, Stinson JE. Role ambiguity, role conflict and satisfaction: moderating effects of individual differences. *J Appl Psy* 1975;60:329-333.
25. Kahn R, Wolfe D, Quinn R, Snock J, Rosenthal R. *Organizational stress*. New York: John Wiley & Sons, Inc. 1964.
26. Miles RH, Perreault WD, Jr. Organizational role conflict: its antecedents and consequences. *Organ Beh H* 1976;17:19-44.
27. Rizzo JR, House RJ, Lirtzman SI. Role conflict and ambiguity in complex organizations. *Adm Sci Qua* 1970;15:150-163.
28. Swenson TG, Belt JA, Sweeney AB. Measurement of job satisfaction (AFOSR Tech. Rep. 104). Arlington: Air Force Office of Scientific Research 1975.

29. Nie NH, Hull CH, Jenkins JG, Steinbrenner K, Bent DH. Statistical package for the social sciences (2nd ed.). New York: McGraw-Hill Book Co, 1981.
30. Fairweather, GW & Tornatzky, LG. Experimental methods for social policy research. New York: Pergamon Press, 1977.
31. Tatsuoaka, MM. Selected topics in advanced statistics (Vol. 6): discriminant analysis. Champaign, Ill: Institute for Personality and Ability Testing, 1970.
32. Dillman, DA. Mail and telephone surveys: the total design method. New York: John Wiley & Sons, 1978.

Table 1. Summary of Significant Pearson r Correlations
of Stressors and Job Dissatisfaction

(N=71)

<u>Potential Stressor</u>	<u>Job Satisfaction Criterion</u>			
	Work Unit	People	Supervision	Pay
Resenting Demands	0.4951**	0.3859**	0.3854**	0.3026*
Self Depreciating	0.4366**	0.2764*	0.3145*	-----
Loss of Control	0.5022**	-----	0.3184*	-----
Goal Stress	0.4756**	-----	-----	-----
Time Stress	0.4453**	-----	-----	-----
Regret	0.3022*	-----	-----	-----
Role Stress	0.4327**	-----	-----	-----
Attention Seeking	-----	0.2909*	-----	0.4059**
Financial Stress	-----	-----	-----	0.4549**
Reactive	-----	-----	0.3262*	-----

-----No significant correlations

* $p < .01$

** $p < .001$

Table 2. Reasons Cited for Leaving Respiratory Care
(in order of importance in the decision)

Item*	Mean rank	S.D.	N
1) More job satisfaction	2.7931	1.0804	29
2) Better salary	3.0690	1.7099	29
3) Lack of opportunities for advancement			
	3.8276	2.0541	29
4) More status or recognition	4.0345	2.2596	29
5) More control over work environment			
	4.7241	2.0336	29
6) Better work schedule	4.7931	1.8201	29
7) Better benefits	5.4138	1.3501	29
8) Full-time mother	6.2500	3.0586	20
No answer			4
Total = 33			

*These items may influence the decision to leave Respiratory Care, but do not account for the influence of stress on the decision.

Table 3. Predictor Variables for
Staying in/Leaving Respiratory Care

Leaving (N = 33)	
<u>Predictor variable</u>	<u>d</u>
Supervision	0.65416
Role Stress	0.62455
Goal Stress	0.55904
Financial Stress	0.30410
People	0.24916
Staying (N = 33)	
<u>Predictor Variable</u>	<u>d</u>
Performance Comfort	0.65879
Regional Aspects	0.46958
Self Appreciation	0.39672
Proactive	0.36227
Eigenvalue = 0.94732 Canonical Correlation = 0.6974775	
Wilk's Lambda = 0.5135252 Chi Squared = 34.656	
Degrees of Freedom = 24 Significance = 0.0737	

Actual Group	No. of Cases	Predicted Group Membership	
		Staying	Leaving
Staying	33	26 78.8%	7 21.2%
Leaving	33	5 15.2%	28 84.8%
Percent of "Grouped" Cases Correctly Classified: 81.82%			

*The standardized discriminant coefficients ($\underline{d}$) are ranked in order of their relative contribution to the decision to leave or stay in Respiratory Care. For example, the variable of role stress makes about a two times greater contribution to the decision to leave than financial stress.